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**Issue Date: 28 August 2007**

In the Matter of

ESTATE OF C.O.P. and O.K.P.
(Deceased Claimants)
v.

CLINCHFIELD COAL COMPANY
Employer

and

THE PITTSTON COMPANY
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Case Nos. 2005-BLA-05933
and 2005-BLA-05934

Attorneys: Joseph Wolfe, Esq.
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For the Claimant

Timothy Gresham, Esq.
Penn Stuart
For the Employer

Before: William S. Colwell
Administrative Law Judge

## DECISION AND ORDER DENYING BENEFITS

This proceeding arises from claims for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. The Act and applicable implementing regulations, 20 CFR Parts 718 and 725, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201. In this case, the Estate of the Claimants, O.K.P., the miner, and C.O.P., his

deceased widow, alleges, on behalf of the deceased claimants, that the miner was totally disabled due to pneumoconiosis and that his death was due to pneumoconiosis.

Pursuant to the Claimants' motion to have the cases decided based on the record, I granted the motion in an Order dated January 4, 2006. I have admitted into evidence Administrative Law Judge Exhibits ("ALJX") 1-5, Employer's Exhibits ("EX") 1-6, and Director's Exhibits ("DX") 1-71. Claimants did not submit any additional exhibits. Both parties submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

## PROCEDURAL HISTORY

The miner filed his initial claim on March 31, 1979, and the claim was denied by Administrative Law Judge Russell M. King, Jr. in a decision and ordered rendered September 30, 1988. Judge King adjudicated the claim under 20 C.F.R. Part 727 and § 410.490. He found that the miner had established more than 24 years of coal mine employment and that Clinchfield Coal was the responsible operator. He further found that Claimant had failed to invoke the rebuttable presumption of entitlement, because he failed to establish the existence of pneumoconiosis by x-ray or total disabling respiratory or pulmonary impairment by either pulmonary function studies, blood gas studies, or medical opinions. DX 1. The miner was discharged from military service with a hundred percent disability due to war wounds from WWII; his left leg was amputated below the knee. After returning to civilian life, he continued working as a coal miner using a prosthesis.

The miner filed a second claim on January 16, 2004. DX 3. Because it was filed more than one year after the prior denial, it is a subsequent claim governed by 20 C.F.R. § 725.309. The miner died on February 13, 2004, and his widow filed a survivor's claim on June 3, 2004. DX 38. In Proposed Decisions and Orders dated January 28, 2005, a Department of Labor claims examiner awarded benefits on both claims. DX 62. The Employer requested a hearing on February 10, 2005. DX 64. The claims were referred to this office on May 18, 2005. (DX 69).

## APPLICABLE STANDARDS

Since the miner's subsequent claim and the widow's claim were filed after January 19, 2001, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2. In order to establish entitlement to benefits under Part 718, the Claimant must establish that the miner suffered from pneumoconiosis, that his pneumoconiosis arose at least in part out of his coal mine employment, that he was totally disabled, and that the pneumoconiosis was a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. 20 CFR §§ 718.1, 718.202,

718.203 and 718.204. In the widow's claim, it must also be established that pneumoconiosis caused the miner's death. § 718.205.

## ISSUES

The following are the contested issues:

1. Whether the miner's claim was timely filed.

2. Whether the Claimant was a miner.

3. Whether the miner established 34 years of coal mine employment.

4. Whether Clinchfield Coal Company is the responsible operator.

5. Whether the widow was an eligible survivor.

6. Whether the widow had any dependents for augmentation of benefits.

7. Whether the miner suffered from pneumoconiosis.

8. Whether the miner's pneumoconiosis arose out of his coal mine employment.

9. Whether the miner was totally disabled.

10. Whether the miner's disability was due to pneumoconiosis.

11. Whether the miner has demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final, pursuant to § 725.309(d).

12. Whether the miner's death was due to pneumoconiosis.

DX 69. (Employer did not address issues 1-6 in its closing argument, but neither did Employer indicate the withdrawal of any issues.)

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

### Factual Background

The miner was born July 12, 1922 and died February 13, 2004. He and his wife were married in January 1948 and remained married and living together until the miner's death. His widow was born December 1, 1925, and she claimed no dependents. DX 38. At the prior hearing, the miner testified that he left coal mining in 1978, because the work became too hard for him to perform because of his shortness

of breath. He also described arthritis and a heart problem. The claimant stated that he smoked about one pack of cigarettes a day for about 15 years before quitting in 1979.

Claimant's last coal mine employment was in Virginia. DX 1. Therefore, this claim is governed by the law of the 4th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

## Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner." 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001).

Employer has not set forth its argument as to why the miner's claim is untimely. I find no evidence that a medical determination of total disability due to pneumoconiosis was communicated to the miner more than three years prior to the filing of the current claim. Thus, I find this claim is timely.

## Miner, Length of Coal Mine Employment, and Responsible Operator

Employer also contests the length of the miner's coal mine employment. The miner alleged 34 ½ years in his subsequent claim. Judge King found more than 24 years of coal mine employment based on the Employment History form, statements from four separate coal companies, the miner's testimony, and counsels' statements. DX 1.

The Social Security records confirm 31 years of coal mine employment between 1939 and 1978. DX 41. Those employers included H&E Harman Coal Corporation; Clinchfield Coal Company; Feds Creek Coal Company; DJB Collieries Inc.; and The Pittston Company. The Pittston Company is also known as Clinchfield Coal Company, at least concerning these claims, based on a letter from the Personnel Department of Clinchfield Coal Company, confirming the miner's employment there from June 8, 1960 to June 23, 1978. DX 40. Claimant described his work for Clinchfield as underground working as a fire boss, repairmen, mechanic, and electrician. DX 39. Based on the foregoing, I find that the Claimant was a miner who established 31 years of coal mine employment and that Clinchfield Coal Company is the properly designated responsible operator.

## Medical Evidence

### Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations are found at 20 CFR § 718.102 and Appendix A of Part 718. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b).

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH).[1] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

| Date of X-ray/ reading | Readers' Qualifications (all are doctors) | Reading and Film Quality | Result Concerning Presence of Pneumoconiosis |
|---|---|---|---|
| DX 31<br>12/17/03<br>12/07/04 | Hayes<br>B, BCR | 1/1; p/p/Quality 3 | Positive (Employer's evaluation) |
| DX 31<br>01/03/04<br>12/07/04 | Hayes<br>B, BCR | 1/1; p/p/Quality 3 | Positive (Employer's evaluation) |

[1]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval.

Pulmonary Function Tests

Pulmonary function tests (PFT) are performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. If there is greater resistance to the flow of air, there is more severe lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second ($FEV_1$) and maximum voluntary ventilation (MVV). The quality standards for PFTs are found at 20 CFR § 718.103 and Appendix B. The following chart summarizes the results of the PFTs available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary test, the $FEV_1$ must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the $FEV_1$/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i).

| Ex. No.<br>Test Date<br>Physician | Age<br>Height | $FEV_1$<br>Pre-/<br>Post | FVC<br>Pre-/<br>Post | $FEV_1$/<br>FVC<br>Pre-/<br>Post | MVV<br>Pre-/<br>Post | Qualify? | Physician<br>Impression |
|---|---|---|---|---|---|---|---|
| DX 2<br>04/24/01 | 78<br>66" | 3.57 | 5.62 | 63% | 132 | No | Good cooperation and understanding |
| DX 31<br>11/05/01 | 79<br>66 | 2.28<br>3.04 | 3.55<br>3.87 | 64%<br>78% | 103<br>-- | No<br>No | Essentially normal; minimal reduction in corrected diffusion capacity of uncertain significance |

CT Scans

The miner underwent a CT scan of the chest on December 5, 2003. Dr. Thomas M. Hayes, a board-certified radiologist, interpreted the scan on December 8, 2004. DX 31. He found a large right-sided pleural effusion occupying much of the right posterior and pleural space. In the apices he saw a minimal degree of occupational pneumoconiosis bilaterally.

On December 17, 2003, the miner underwent a chest CT at Bristol Regional Medical Center. DX 31. Dr. Jack M. Hoffnung interpreted the scan as showing a pulmonary embolus in the let upper lobe, a mass in the right hilum, atelectasis in the right lung with some progression of infiltrate in the right upper lobe, and multiple pulmonary nodules.

Dr. Hayes read the December 17, 2003 scan on December 8, 2004. He found extensive atelectasis in the right infra-hilar area, and he could not exclude a neoplasm. He also detected the suggestion of subpleural nodules and a minimal degree of nodular fibrosis "suggesting the possibility of a minimal degree of occupational pneumoconiosis."

Death Certificate

Claimant died on February 13, 2004, and Dr. Raya E. Kheirbek completed the death certificate. DX 44. She listed the cause of death as metastatic lung cancer.

Autopsy Reports

Dr. Perper

Dr. Joshua Perper performed an autopsy of the heart and lungs on February 20, 2004. DX 47. In addition to the autopsy, he considered 34.5 years of coal mine employment and a history of smoking until 1961. Upon gross examination, Dr. Perper detected "innumerable anthracotic macules measuring up to 0.3 – 0.4 cm, and scattered firm anthracotic nodules measuring up to 0.6 cm" in the left lung, where he also found slight-to-moderate centrilobular emphysema. Dr. Perper's microscopic examination of the right lung revealed an adenocarcinoma tumor; slight-to-moderate centrilobular emphysema; areas of bronchopneumonia; and scattered anthracotic pneumoconiotic macules and small micronodules. In the left lung, Dr. Perper found: "round or oval, silicotic type of pneumoconiotic nodules, exceeding 1.0 cm in maximal dimension." He also detected "scattered pneumoconiotic micronodules measuring up to 5-6 mm of both the mixed coal anthracotic type and the silicotic type."

Dr. Perper's final anatomical diagnoses include mucinous adenocarcinoma; coal workers' pneumoconiosis with macronodules exceeding 1.0 cm and "therefore consistent with complicated coal workers' pneumoconiosis;" centrilobular emphysema; areas of bronchopneumonia; sclerosis of the intra-pulmonary blood vessels consistent with pulmonary hypertension and cor pulmonale; coronary arteriosclerosis; and cardiomegaly.

Dr. Perper opined that the miner had severe and extensive pulmonary cancer as well as clear evidence of significant coal workers' pneumoconiosis with nodules exceeding 1.0 cm, "and therefore qualifying for a diagnosis of complicated coal workers' pneumoconiosis." He added that "[a] substantial body of scientific literature has documented that occupational exposure to silica (or coal dust containing silica), an

acknowledged carcinogen for humans is a risk factor for pulmonary cancer and can result in pulmonary cancer." He opined that the miner had more than sufficient coal mine dust exposure and severe enough CWP to develop related lung cancer. Finally, Dr. Perper averred that:

> pulmonary cancer, coal workers' pneumoconiosis and arteriosclerotic coronary artery disease, were in aggregate substantial causes of death and hastening factors in the death of [the miner]. A definitive and totally reliable determination as to the precise roles and magnitude of the above pathological conditions in the death of [the miner] requires the integration of the autopsy findings with the clinical and laboratory findings and the circumstances of death.

Dr. Perper is board certified in anatomical, surgical, and forensic pathology.

Dr. Bush

Dr. Stephen T. Bush reviewed the histologic slides and other medical documents in a report dated October 13, 2004. DX 60. The medical records date back to 1979. Dr. Bush opined that the miner had a mild-to-moderate degree of simple coal workers' pneumoconiosis. He further explained:

> The histologic slides show black dust pigment free in the tissue and in macrophages associated with a fibrous reaction forming nodular lesions with surrounding focal dust emphysema of moderate degree. Some lesions measure 1 cm in length but no lesion measures 1 cm in diameter. The largest lesions are elongated along the edge [of] the lung beneath the pleura. Polarized light examination reveals birefringent particles of silicates and fewer particles of silica. The coal mine dust disease including macules, nodules and focal dust emphysema destroys approximately 5 percent of the lung tissue estimated by examination of the histologic slides in conjunction with the radiologic reports and autopsy gross description.
>
> The lesions do not indicate progressive massive fibrosis, as Dr. Perper concludes. The lesions in [the miner] satisfy few if any of the criteria found in the *Archives of Pathology* (1979).
>
> > "Lesions are solid, heavily pigmented, rubbery to hard."
> > "They frequently cross and obliterate lobar and lesser fissures."
> > "By definition, the lesion is at least 2 cm in diameter."
> > "The remainder of the lung . . . is almost invariably heavily pigmented."
>
> The 2 cm in diameter criterion was selected by the pathologists establishing the criteria because this dimension permits better correlation with clinical and roentgenographic measurements than smaller lesions. It

> is noteworthy that the pathologists establishing the standard refer to a lesion 2 cm in diameter not simply 2 cm in greatest dimension. A lesion 2 cm in greatest dimension could be any measurement in other dimensions from pencil thin or less making such a criterion meaningless. The lesions in [the miner] are 0.5 cm or less in thickness, making them inappropriate indicators for the diagnosis of progressive massive fibrosis.
>
> The references by Dr. Perper do indicate a definition of progressive massive fibrosis as lesions greater than 1 cm in diameter rather than 2 cm. Note that the criterion refers to diameter rather than the greatest dimension of a lesion. The accompanying photographs illustrating progressive massive fibrosis are in no way reminiscent of the lesions by size, color or character that are found in [the miner].

Dr. Bush further opined that the miner's degree of pneumoconiosis—an estimated 5% destruction of lung tissue--was too limited to have caused or substantially contributed to respiratory impairment. He also asserted that pneumoconiosis did not contribute to or hasten the miner's death. Dr. Bush stated that the miner died of carcinoma of the lung that almost completely obliterated the right lung. He also disagreed with Dr. Perper regarding a connection between coal dust exposure and lung cancer. He stated that people who are "heavily exposed to silica are at higher risk for the development of carcinoma, but evidence for similar effects of coal dust do not show an increased risk." Indeed, he explained that studies have shown a decreased risk of lung cancer in coal miners. Finally, Dr. Bush opined that the miner died of lung cancer unrelated to his simple CWP and that he would have died at the same time and in the same manner even if he had never been exposed to coal mine dust. Dr. Bush is board certified in anatomic and clinical pathology as well as medical microbiology.

Dr. Caffrey

In a report dated November 12, 2004, Dr. P. Raphael Caffrey reviewed the histologic slides and the same medical records that Dr. Bush considered. DX 61. He diagnosed moderately differentiated adenocarcinoma of the right lung; a moderate degree of simple coal workers' pneumoconiosis; and moderate centrilobular emphysema. He disagreed with Dr. Perper's diagnosis of complicated pneumoconiosis for these reasons:

> In the gross description of the left lung Dr. Perper describes nodules of 0.7 cm, 0.3-0.4 cm, and nodules measuring up to 0.6 cm. Dr. Perper does not describe any nodules in the right lung and microscopic examination shows from a review of the slides that the CWP nodules were present in the left lung.

I am not certain how Dr. Perper then in his microscopic examination says "**nodules exceeding 1.0 cm are present in examination of the slides from the left lung**" when grossly he does not describe any lesions approaching 1.0 cm; the largest described was 0.7 cm.

The largest lesion I measured was 0.9 cm microscopically but that measurement was a longitudinal measurement. There were no nodules which measured more than 0.5 cm in diameter.

In the "Pathology Standards for Coal Workers' Pneumoconiosis" published in the Archives of Pathology and Laboratory Medicine in July 1979 under Progressive Massive Fibrosis or Complicated Pneumoconiosis the authors say and I quote: "**By definition, the lesion is at least 2.0 cm in diameter**." They go on to say that others have said 3.0 cm or 1.0 cm and even if you establish and accept the 1.0 cm size as a standard, that is a lesion 1.0 cm in diameter and none of the lesions in [the miner's] lung tissue were 1.0 cm in diameter. Dr. Perper on page 5 of his report refers to Spencer's 1996 authoritative textbook of Pathology of the Lung. I have in front of me copy of Spencer's textbook entitled Pathology of the Lung, 5th edition, 1996. On page 479 of the textbook the authors state and I quote: "**The PMF lesions which by definition are greater than 1.0 cm in diameter nearly always occur on a background of severe simple pneumoconiosis. The lesion is typically soft, jet black, homogenous and well delineated and may show varying degrees of cavitations. The centers of the lesion may evidence necrosis and cholesterol clefts.**" The microscopic characteristic of these lesions of [the miner] are not those of lesions of complicated pneumoconiosis. [The miner] did have a number of lesions of simple CWP along with micro- and a rare macronodule.

Dr. Perper notes that a substantial body of literature has documented that occupational exposure to silica, an acknowledged carcinogen for humans is a risk factor for pulmonary cancer and can result in pulmonary cancer. The amount of silica in the lesions of simple CWP in [the miner's] lungs was minimal. Numerous studies have shown that there is no increase in risk for carcinoma in coal miners. I am aware of no acceptable reference in the literature which says coal miners are at increased risk for developing carcinoma. In the textbook Pathology of Occupational Lung Disease, 2nd edition by Churg and Green the authors state and I quote: "**When adjusted for cigarette smoking, the majority of coal miner mortality studies show that lung cancer occurs slightly less frequently in coal miners than in comparable populations**."

I disagree with Dr. Perper in his final diagnosis when he says there was sclerosis of intra-pulmonary blood vessels consistent with pulmonary hypertension and cor pulmonale. That is a subjective statement. The

> patient had two echocardiograms, which during lifetime is a significant and important test to determine size of the right and left heart for example, and both echocardiograms on 5/15/02 and 2/28/03 were interpreted as normal right heart or normal right atrium and right ventricle. In the textbook again Pathology of Occupational Lung Disease, 2nd edition by Churg and Green the authors state and I quote: "**With increasing age the media of muscular pulmonary arteries becomes irregular; muscle is replaced by collagen and the intima shows patchy and progressive fibrosis. These changes are more pronounced in cigarette smokers. Although these changes are anatomically abnormal, they are not associated with pulmonary hypertension or cor pulmonale and thus have no obvious clinical significance**."
>
> Dr. Perper in his conclusion fails to note the fact that [the miner] had a significant smoking history which on at least two occasions was documented at one pack per day for 30 days. Smoking is not only a major or leading cause of carcinoma of the lung but also one of the major causes of cardiovascular disease from which the patient suffered, and also COPD which some physicians diagnosed [the miner] as having.

Dr. Caffrey opined that the miner's coal dust exposure did not cause him any significant pulmonary disability and did not cause, contribute to, or hasten his death. He stated that the miner's death was due to carcinoma of the lung that caused a malignant pleural effusion with metastasis to the diaphragm. Dr. Caffrey is board certified in anatomic and clinical pathology.

Hospital Records

The miner was admitted to the Bristol Regional Medical Center, where Dr. Brett C. Odum attended him from November 27-28, 2003. DX 31. He complained of shortness of breath and believed that fluid had reaccumulated in his right lung. The miner underwent a thoracentesis. Dr. Charles A. Bolick consulted, and based upon a physical examination, x-ray, medical history, family history, a history of last smoking 20 years earlier, and a history of coal mining for 30 years, he diagnosed recurrent pleural effusion, coronary artery disease with normal left ventricular function, and hypertension.

On December 12, 2003, Dr. D. Glenn Pennington performed a right thoracoscopic pleurodesis. DX 31. Based on that surgery he diagnosed recurrent right malignant pleural effusion.

The miner was again hospitalized from December 4-22, 2003 at Wellmont Bristol Regional Medical Center. He underwent a bronchoscopy and a right thoracoscopic pleurodesis after presenting with recurrent pleural effusion with worsening dyspnea. Dr. Bolick made ten diagnoses, including moderately differentiated adenocarcinoma of the lung; acute pulmonary embolism; hypertension; and coronary artery disease. A biopsy of the right lower bronchus revealed that the miner's moderately differentiated

adenocarcinoma was consistent with primary pulmonary cancer, according to Dr. Jack T. Bechtel. EX 1. The cytology report confirmed the diagnosis of adenocarcinoma. EX 2, 3.

The miner was admitted to the Veterans' Administration Hospital on February 11, 2004, where he stayed until his death on February 13, 2004. DX 31. The discharge summary indicates that he had terminal lung cancer and was admitted due to challenging care needs. He was short of breath and was diagnosed with post-obstructive pneumonia.

Treatment Records

Dr. P.K. Rohatgi provided a pulmonary consultation on January 7, 2004. DX 31. He considered a medical history, a history of last smoking 35 years earlier, a history as a coal miner, the results of a physical examination, an x-ray, and a CT scan. He found no evidence of pneumoconiosis by CT or x-ray. Dr. Rohatgi diagnosed bronchiogenic adenocarcinoma and a history of coronary artery disease.

## DISCUSSION AND APPLICABLE LAW

### Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d).

Because the miner's original claim was denied for failure to establish pneumoconiosis or a total disabling pulmonary or respiratory impairment, I must initially determine whether the newly submitted evidence establishes one of these conditions of entitlement.

In this case the Employer has conceded in its closing argument that the miner suffered from simple coal workers' pneumoconiosis. This is supported by the most recent x-ray evidence and the CT scans, all read by Dr. Hayes on behalf of the Employer. It is also supported by the autopsy evidence. Dr. Perper, the autopsy prosector, and Drs. Bush and Caffrey, who reviewed the autopsy slides and other medical evidence for the Employer, agree that the miner had CWP. Accordingly, I find that the miner has established pneumoconiosis. As such, the miner has demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final, pursuant to § 725.309(d).

All the medical evidence of record must now be considered to determine if the miner has established the other conditions of entitlement. The medical evidence

generated in conjunction with the prior claim is set forth in Judge King's decision and order found at DX 1 and is incorporated by reference herein without duplication.

The medical opinions considered by Judge King are from Dr. Baxter and Dr. Byers who examined the miner in 1979, Dr. Sherrod who examined the miner in 1980, Dr. Sargent who examined the miner in 1985, and Dr. Robinette who examined the miner in 1987. Dr. Baxter declared the miner totally disabled and noted a progressive pulmonary disease as a result of occupational exposure, but he did not specifically link the two. Nor did he rule out pneumoconiosis as a cause of impairment. Dr. Byers found a surprisingly normal pulmonary status but did not provide an opinion as to disability or its cause. Dr. Sargent attributed the miner's total disability to his leg amputation and war wounds. Dr. Sargent felt that the miner had no ventilatory impairment, and he found no evidence of coal workers' pneumoconiosis. Dr. Sherrod felt that the miner's total disability was not related to black lung disease or coal mine dust exposure in any way. Dr. Robinette opined that the miner had pneumoconiosis but believed it caused only mild to moderate respiratory symptoms. He opined that dust exposure would probably render the miner short of breath and coughing, but Dr. Robinette did not otherwise address the issue of total disability.

Of the newly submitted evidence, Dr. Perper opined that CWP, along with cancer and coronary artery disease, were substantial causes of the miner's death. DX 47 He did not specifically address disability. Dr. Bush asserted that the miner's degree of pneumoconiosis was too limited to have caused or substantially contributed to his respiratory impairment or death. DX 60 Dr. Caffrey stated in his medical opinion that he believed the miner's coal dust exposure did not cause him any significant pulmonary disability and did not hasten his death. DX 61 During his deposition cross-examination, he stated he could not know if the CWP would have "hastened, in any way, however small [the miner's] death." EX 6, pgs. 35-36 The hospital records, treatment records, and death certificate do not provide opinions regarding the cause of the miner's disability.

Regarding the older evidence, I find that it merits less weight in general because the examinations took place between 1979 and 1987, and the miner lived until 2004—an additional 17-25 years for his pneumoconiosis to advance and for disability to worsen. *Cosalter v. Mathies Coal Co.*, 6 BLR 1-1182 (1984). Dr. Sherrod examined the miner for his orthopedic complaints, so I do not give his opinion as much weight as those of the pulmonary specialists. Dr. Baxter obliquely connected the miner's pulmonary disease and total disability, so his opinion does not rule out pneumoconiosis as the cause. Dr. Robinette felt that the miner's pneumoconiosis caused some respiratory symptoms; he did not rule out pneumoconiosis as a cause of disability. Dr. Byers found normal pulmonary status, and Dr. Sargent found no impairment or pneumoconiosis. I place no weight on Dr. Sargent's opinion since the evidence now establishes pneumoconiosis. The more recent pulmonary evidence of record contradicts Dr. Baxter's opinion. Therefore, I discount his opinion. For these reasons, I place no or very little weight on the medical opinions generated in conjunction with the miner's original claim.

Dr. Perper did not address the cause of the miner's disability. Dr. Caffrey believed that the miner's coal dust exposure did not cause him any significant pulmonary disability. This opinion fails to "rule out" pneumoconiosis as a cause of disability. Dr. Caffrey merely opined that it did not cause "significant" pulmonary disability. Dr. Bush asserted that the miner's degree of pneumoconiosis was too limited to have caused or substantially contributed to his respiratory impairment. His opinion is based on a review of all the medical evidence of record, including the non-qualifying PFT's and ABG's, as well as the autopsy slides. Thus, I consider it well documented and well reasoned. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). His qualifications as a board certified pathologist and microbiologist lend further credence to his opinion. I found his explanation contradicting Dr. Perper's finding of complicated pneumoconiosis (as set forth below) compelling and bolstered by Dr. Caffrey's opinion. As a result, I find that Dr. Bush's opinion as to the extent of the miner's pneumoconiosis and the degree to which it would have caused any disability is entitled to great weight.

As previously noted, the Employer concedes on brief that the miner suffered from simple, but not complicated, pneumoconiosis.

In this case, § 718.304 applies. It provides that if a miner suffered from a chronic dust disease of the lung which is diagnosed by: (a) an x-ray yielding one or more large opacities (greater than 1 centimeter in diameter and classified as Category A, B, or C); (b) biopsy or autopsy that yields massive lesions in the lung; or (c) other means that could reasonably be expected to yield the results described above, then such miner shall be presumed to have been totally disabled due to pneumoconiosis. It also provides for an irrebuttable presumption that a miner's death was due to pneumoconiosis.

Evidence under § 718.304(a), (b), and (c) must be weighed together to determine if Claimant is entitled to the irrebuttable presumption. *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000). "Evidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict." *Id.* at 256. The Fourth Circuit, under whose jurisdiction this claim is governed, also mandates that the administrative law judge make an equivalency determination when there is a question about whether nodules found in the lung by autopsy would correspond to opacities viewed on an x-ray indicating complicated pneumoconiosis. *Scarbro*, 220 F.3d 250 (4th Cir. 2000); *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999). Such an equivalency determination insures that, "regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption." *Braenovich v. Cannelton Industries, Inc.*, 22 BLR 1-236 (2003); *Blankenship*, 177 F.3d at 243. The administrative law judge is not bound by what appears to be the pathologic standard that a nodule must be 2 centimeters on autopsy to appear as a 1-centimeter nodule on x-ray.

## Medical Evidence

### § 718.304(a) – X-ray Evidence

None of the x-rays of record was read as showing complicated pneumoconiosis through large opacities categorized as A, B, or C. Accordingly, the x-ray evidence alone does not establish complicated pneumoconiosis.

### § 718.304(b) – Autopsy Evidence

The most probative evidence of complicated pneumoconiosis in this case is the autopsy evidence. In this case, Dr. Perper performed the autopsy and Drs. Bush and Caffrey reviewed the autopsy slides.

Dr. Perper made a diagnosis of complicated pneumoconiosis based on his finding of pneumoconiotic nodules "exceeding 1.0 cm in maximal dimension." He provided photographs of the lung sections he examined. In describing figure 2, a lung section from the left lung at 1:3 magnification, he wrote that there was an "anthraco-silicotic type of micronodule pleural/subpleural, measuring more than 1.2 cm (12 mm) in length and extending for a depth of 0.5 cm (5 mm) within the underlying pulmonary parenchyma." Dr. Perper did not provide any statement as to whether the largest nodules would appear as one-centimeter nodules on x-ray.

Dr. Bush did not diagnose complicated pneumoconiosis. He referred to the medical requirement that such lesions measure at least 2 cm in diameter on autopsy to equal 1 cm in diameter by x-ray. However, he also pointed out that in this case, there were lesions measuring 1 cm in **length** but not **diameter**.

Dr. Caffrey also did not diagnose complicated pneumoconiosis. He pointed out that Dr. Perper did not describe any nodules on gross examination as measuring at least 1 cm, and therefore, could not understand the basis for Dr. Perper's finding a 1 cm nodule microscopically. Dr. Caffrey stated that the largest lesion he saw was 0.9 cm longitudinally, and none of the nodules were greater than 0.5 cm in diameter. Like Dr. Bush, he further stressed that Dr. Perper did not specify that he found any nodule at least 1 cm in **diameter**.

In *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 22 BLR 2-94 (4th Cir. 2000), the Fourth Circuit addressed the question of invocation of the irrebuttable presumption in § 718.304. The court held that each of the three methods set out in that section of the regulations for invoking the presumption is meant to reflect the same condition. Therefore, to invoke the presumption by autopsy evidence, a diagnosis of "massive lesions" must be the equivalent of a diagnosis by x-ray of large opacities greater than 1 cm. in diameter. In other words, if a pathologist finds a large lesion in the lung that measures, *e.g.*, 1.2 cm., the pathologist must indicate whether a lesion that size found in a miner's lung tissue would also measure more than 1 cm. if it were viewed on an x-ray. Dr. Perper did not made such a comparison, and, as pointed

out by both Dr. Bush and Dr. Caffrey, did not assert that the 1.0 cm lesion he found was 1.0 cm in **diameter**. Accordingly, the autopsy evidence fails to establish complicated pneumoconiosis.

§ 718.304(c) Other Evidence

The medical opinions also fail to establish complicated pneumoconiosis. None of the physicians providing medical opinions generated in support of the original claim diagnosed complicated pneumoconiosis. DX 1. The only medical opinions submitted in conjunction with this claim are those of Dr. Bush and Dr. Caffrey. Their opinions have been discussed above—they opined that the miner did not have complicated pneumoconiosis. None of the CT scans was read as showing complicated pneumoconiosis. Consequently, there is no medical opinion evidence in support of a finding of complicated pneumoconiosis.

In summary, the evidence fails to invoke the irrebuttable presumption of §718.304. There is no x-ray evidence of an opacity in the miner's lung greater than 1 cm. in diameter or a diagnosis by autopsy or medical opinion of massive lesions in the miner's lungs which, if diagnosed by x-ray, would exceed 1 cm. in diameter. Further, the CT scans do not tend to prove the existence of complicated pneumoconiosis under subsection (c) of §718.304.

Pneumoconiosis Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). As I have found 31 years of coal mine employment, the miner is entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of coal mine employment. I do not find that Employer has rebutted this presumption.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2004), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment. 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2004). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2004); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994).

Pulmonary Function Tests

None of the eight pulmonary function studies conducted between April 2, 1979 and April 28, 1987 produced qualifying values. DX 1. There are two newly submitted pulmonary function studies, and neither yielded qualifying values. Therefore, I conclude that the pulmonary function study evidence does not establish total disability pursuant to § 718.204(b)(2)(i).

Arterial Blood Gas Studies

Of the four blood gas studies submitted in connection with the miner's original claim, none yielded qualifying values. No blood gas studies have been submitted in conjunction with the subsequent claim. Thus, I find that the blood gas study evidence does not establish total disability pursuant to § 718.204(b)(2)(ii).

Cor Pulmonale

Section 718.204(b)(2)(iii) provides for the finding of total disability if there is evidence of cor pulmonale with right-sided congestive heart failure. Dr. Perper made a finding of "sclerosis of the intra-pulmonary blood vessels consistent with pulmonary hypertension and cor pulmonale." He did not, however, make the concomitant finding of right-sided congestive heart failure. Furthermore, Dr. Caffrey disagreed with that finding. He felt it was a subjective statement and referred to two echocardiograms from May 2002 and February 2003, neither of which revealed any abnormality of the right side of the miner's heart. Because Dr. Perper's opinion does not meet the standard under § 718.204(b)(2)(iii) and because Dr. Caffrey's disagreement is supported by the underlying echocardiograms, I find that the evidence does not establish total disability pursuant to this section.

Medical Opinions

I must next consider the medical opinions. The Claimant can establish that the miner was totally disabled by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be

rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician, as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2004). The Sixth Circuit has interpreted this rule to mean that:

> in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

*Eastover Mining Co. v. Williams*, 338 F.3d 501, 513 (6th Cir. 2004) (citations omitted).

Based on the reasoning set forth above, I discount the opinions of the physicians who examined the miner between 1979 and 1987, leaving the opinions of Drs. Perper, Bush, and Caffrey. Dr. Perper limited his opinion to the cause of the miner's death; he did not address total disability. Dr. Bush stated that the degree of pneumoconiosis was too limited to have caused or substantially contributed to respiratory impairment during the miner's lifetime. He further found that the estimated five percent destruction of lung tissue by CWP would not have produced signs or symptoms of pulmonary disease. The more recent pulmonary evaluations support the opinion by Dr. Bush. Dr. Caffrey concluded after reviewing the medical records the miner's CWP did not "cause any significant pulmonary disability." He did not provide an opinion regarding the extent of the miner's pulmonary disability. Consequently, I find that the medical opinion evidence does not establish total disability. When I consider all the evidence under this section, it fails to establish the existence of a total pulmonary disability by a preponderance of the evidence. Therefore, the miner's claim for benefits must be denied.

Death Due to Pneumoconiosis

The widow filed her claim on June 3, 2004. Therefore, entitlement to benefits must be established under the regulatory criteria at Part 718, as amended effective January 19, 2001. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. An eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death; or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis; or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

§ 718.205(c).

In order to be eligible for benefits, a widow must prove that the miner's death was caused by pneumoconiosis. Although the Benefits Review Board requires that death must be "significantly" related to or aggravated by pneumoconiosis, the circuit courts have developed the "hastening death" standard which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. The new regulations also adopt this standard. § 718.203(c)(5). In order to recover benefits, widow must prove through medical opinion evidence that pneumoconiosis hastened her ex-husband's death in some manner.

The death certificate, signed by Dr. Kheirbek, lists the cause of death as metastatic lung cancer. Dr. Perper opined that pneumoconiosis contributed to the miner's death in that it put him at risk for pulmonary cancer. He also believed that pneumoconiosis, along with cancer and coronary artery disease, hastened the miner's death. Dr. Bush and Dr. Caffrey asserted that pneumoconiosis did not hasten the miner's death. They attributed death to lung cancer that almost completely obliterated the miner's right lung. Both Dr. Caffrey and Dr. Bush refuted Dr. Perper's linking of coal dust exposure and cancer. They pointed out that silica exposure is a cancer risk, but the same has not been found of coal mine dust.

All three physicians maintain impressive credentials as board-certified pathologists. However, I find that the opinions of Drs. Bush and Caffrey are better reasoned and supported by the underlying evidence, including the miner's smoking history, non-qualifying PFT's and ABG's, and hospital courses. Moreover, the CT scans of 2003 and 2004, and the x-rays from the same time period were read as showing

simple CWP of category 1/1. I have concluded, contrary to Dr. Perper, that the miner did not have complicated pneumoconiosis. Furthermore, Dr. Perper's opinion is stated in less certain terms than those of Dr. Bush and Dr. Caffrey. He alluded to medical literature that shows a link between coal dust exposure and lung cancer but he failed to cite any study or medical article. Drs. Bush and Caffrey, on the other hand, cited text from Pathology of Occupational Lung Disease for the very opposite proposition. For these reasons, I place greater weight on the opinions of Drs. Bush and Caffrey and find that find that the evidence fails to establish that pneumoconiosis hastened the miner's death.

Summary

The preponderance of the evidence fails to establish that the miner was totally disabled by his pneumoconiosis or that his death was caused by, contributed to by, or hastened by coal workers' pneumoconiosis. Thus, both claims must be denied.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimants have failed to meet their burdens to establish that the miner was totally disabled due to pneumoconiosis and that his death was hastened by pneumoconiosis. Consequently, they are not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. See Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimants for services rendered to them in pursuit of these claims.

ORDER

The claims for benefits filed by the miner on January 16, 2004, and the widow on June 3, 2004, are hereby DENIED.

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WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.
WSC:AS

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).